STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445360	A. BUILDING _____ B. WING _____	12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TENNOVA HEALTH CARE-TENNOVA TCU	900 EAST OAK HILL AVENUE KNOXVILLE, TN 37917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey and complaint investigation #33965, were completed on December 15, 2014, through December 17, 2014, at Tennova Transitional Care Unit. A deficiency was cited related to the complaint investigation #33965, under 42 CFR Part 483, Requirements for Long Term Care Facilities.	F 000		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the facility investigation, facility policy review, and interview, the facility failed to ensure a safety device was in place for one resident (#224) of three residents reviewed for accidents of nineteen residents reviewed resulting in a fall with harm. The findings included: Resident #224 was admitted to the facility on May 8, 2014, with diagnoses including Difficulty Walking and Urinary Tract Infection. The resident was discharged from the facility on May 25, 2014.	F 323	F323 1) Immediately upon discovery, the Director of Nursing implemented the following actions for the affected resident: a) A tab alarm was immediately placed on the resident by the assigned nurse. The plan of care was reviewed with 100% of staff specific to the fact that the resident was to have the tab alarm on at all times. b) The resident was assigned a 1:1 sitter during a 6 hour period of increased anxiety on 5/16/14. The resident was monitored each shift regarding level of anxiety.	05/14/14 05/16/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Pamela B. Rogers — TITLE: NHA — (X6) DATE: 1/12/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	Continued From page 1 Medical record review of the Admission Care Plan dated May 8, 2014, revealed "Evidence of Falls Risk...Encourage use of call light...Instruct resident on safety measures...Alarm Type: Bed..." Medical record review of the Fall Risk Assessment dated May 8, 2014, revealed the resident scored 80 (greater than 45 High Risk), and "Interventions Implemented: Low Bed...Patient Education..." Medical record review of the Admission Nursing Assessment dated May 8, 2014, revealed "...Short term memory problem [no recall after 5 minutes]...Orientation person...place...situation...Modified Independent-difficulty in new situations...Ambulates yes...1 person physical assist...walker..." Medical record review of the Admission Minimum Data Set (MDS) dated May 14, 2014, revealed the resident was moderately impaired for cognitive skills for daily decision making, required extensive assistance of one person for bed mobility, transfer, walk in room, and toilet use. Medical record review of the Nursing Note dated May 14, 2014, revealed "...1725 [5:25 p.m.] Pt [patient] fell in bathroom. Did not call for help. CT [Computed Tomography] of head due to hitting head in shower. Neurochecks [and] vitals per fall protocol..." Review of the facility investigation dated May 14, 2014, revealed "...1725 Nurse heard patient call out for help. Found in the bathroom floor on...back. Patient states...walked to the bathroom and as...was turning to use toilet...fell in to the	F 323	2) All residents had the potential to be affected. In order to determine which TCU residents were at risk, the following actions were taken for 100% of TCU residents: a) Each resident was re-assessed by staff Registered Nurses and/or the Director of Nursing utilizing the Morse Fall Scale to ensure fall score and interventions were consistent with resident's assessed needs for fall prevention / safety and consistent with the policy. — 05/30/14 b) Each resident's care plan was audited by staff Registered Nurses and/or the Director of Nursing to ensure consistency with Morse Fall Scale score and validated necessary interventions for fall risk reduction were in place. — 05/30/14 3) a) The Director of Nursing implemented a daily falls safety huddle on the Transitional Care Unit to ensure all staff are familiar with each resident's plan of care. The safety huddle is held 7 days per week, following a set agenda and form, and attended by nursing and ancillary staff. Huddle outcomes are tracked via a log kept on the unit. Any issues — Began 05/15/14 -ongoing	

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F 323	Continued From page 2 shower and hit...head against the shower wall. Patient states...thought...was able to walk alone to the bathroom. Instructed to ask for assistance. Bed alarm applied. Patient complained of back pain after the fall but refused any x-rays the day of the fall..." Continued review of the facility investigation dated May 14, 2014, revealed "...Approximately at 1725 pt fell in bathroom while trying to turn [and] use toilet. Pt fell in to shower [and] hit head against shower wall. Pt. did not ask for help to restroom...figured...was able to go alone, asked pt if therapy told...could go alone...said no, informed pt that therapy will tell you when able...Interventions Pre-Fall call light within reach...Bed low/locked...Frequent rounding...Pt instructed to call...was staff responding to bed alarm when fall occurred?...N/A [not applicable-did not have alarm on]...Recommendation/Action...Fall Precautions...Increase Precautions Bed Alarm..." Medical record review of a Physician's Order dated May 14, 2014, revealed "...CT of Head...lumbar xray if new or worse pain..." Medical record review of a Physician's Order dated May 15, 2014, revealed "...CT Lumbar/Thoracic Spine stat..." Medical record review of the Final Report for CT Thoracic Spine dated May 15, 2014, revealed "...There is diffuse osteoporosis...There is mild to moderate proximally 50 percent compression of T [Thoracic] 7 with some sclerosis and with what appears to be a ununited fracture of the endplate of T7...MRI [Magnetic Resonance Imaging] may be useful to further evaluate the thoracic/upper	F 323	noted during the huddles are brought to TCU leadership for resolution. b) Licensed staff were re-educated by the Director of Nursing on use of Morse Fall Scale and care plan interventions consistent with Morse Fall Scale score and policy. Staff on vacation or FMLA during this timeframe were educated upon return. c) The falls policy was individualized to the specific needs of the Transitional Care unit, and a separate policy entitled "Transitional Care Unit Falls Assessment and Interventions" was developed unique to the unit. d) A computer based learning module was developed, entitled "Falls Continuing Education – Tennova Transitional Care. This module was completed by all TCU employees. e) A Transitional Care Unit fall prevention multidisciplinary team was established and is ongoing utilizing the QAPI process. The team consists of the TCU Administrator, Director of Nursing, Physical Therapist, RN, LPN, UC, Director of Risk Management, and Engineering Manager, with	05/15/14 Policy revised on 5/30/14;Last periodic review date 09/24/14 08/31/14 Began 08/19/14 -ongoing

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F 323	Continued From page 3 lumbar compressions to differentiate chronic compressions from any acute fracture..." Medical record review of the CT Lumbar Spine dated May 15, 2014, revealed "...There is a compression fracture seen involving the inferior endplate of T6. This appears to be acute..." Medical record review of a Physician's Progress Note dated May 15, 2014, revealed "...CT T/L [Lumbar] spine...diffuse osteoporosis...compression fx-[probably] acute...bedrest..." Medical record review of a Physician's Order dated May 15, 2014, revealed "...bedrest, up only [with] assistance to BSC [Bedside Commode]...consult [named orthopedic group]..." Medical record review of the Nursing Note dated May 15, 2014, revealed "...Tab alarm on. Call light [with] in reach, bed low [and] locked. Pt. wants all side rails up..." Medical record review of the MR Thoracic Spine dated May 16, 2014, revealed "...Fall 5/14/14, Abnormal CT, Compression Fracture...Compression fracture seen involving the inferior endplate of T6. This appears to be acute..." Medical record review of the Physician's Progress Notes dated May 19, 2014, revealed "...[named orthopedic group] options discussed...patient has chosen no treatment [at] present..." Review of facility policy, Falls Assessment and Interventions, revealed "...The most common approach to fall prevention is the use of a	F 323	others invited as needed. All staff are encouraged to bring any concerns to the members of this team as well as to Leadership. Team meetings were initially held weekly, progressed to monthly, and are now held quarterly – with called meetings at any time if issues arise which need to be addressed. Results of this team's activities will be forwarded to the facility Quality/Safety Committee. To start with January 2015 QSC meeting f) A hospital-wide Daily Safety Huddle was implemented to identify safety issues such as patient falls, and to identify and decrease barriers to patient safety. A member of TCU participates in this hospital-wide huddle, which fosters consistency in falls prevention initiatives and falls prevention messaging between TCU and the remainder of the facility. Began 08/25/14 -ongoing g) A handoff is also in place through standardized shift reports on TCU that includes patient falls risk status, which clearly identifies patients at risk to fall and interventions currently in place for each patient to prevent falls. Began 08/04/14 -ongoing	

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F 323	Continued From page 4 program of multiple interventions that aims to minimize the patient's risk of falling...High Risk Safety Interventions...The high risk fall prevention safety interventions may be considered in addition to the Low Risk Safety Interventions...Consider use of technology for fall prevention [Tab alarms and/or pressure sensor alarms or other alarms as appropriate]..." Interview with the Director of Nursing (DON), on December 16, 2014, at 8:30 a.m., in the conference room confirmed the tab alarm was not in place at the time of the fall on May 14, 2014. Interview with Licensed Practical Nurse (LPN) #1, on December 16, 2014, at 2:45 p.m., in the conference room confirmed LPN #1 found the resident in the bathroom in the floor on May 14, 2014, and the resident did not have a bed alarm in place at the time of the fall. Interview with the LPN #1, on December 16, 2014, at 3:55 p.m., in the conference room confirmed the resident was in the bed prior to the fall on May 14, 2014. Interview with the Medical Director, on December 17, 2014, at 8:15 a.m.,in the conference room confirmed the acute compression fracture (Harm) was a result of the fall on May 14, 2014.	F 323	4) a) Weekly audits were initiated on a random sample of 30% of average daily census to ensure Morse Fall Scale score is accurate and interventions on care plan are consistent with Morse Fall Scale score and validated to be consistent with actions in place in the POC. b) Random audits will continue until 6 consecutive months of full compliance is achieved. c) Audits are performed by staff nurses, the Director of Nursing, and the TCU Administrator, and any noted deficiencies are addressed with the involved staff members. Results of random audits and actions taken in response to results are aggregated, analyzed, and trended at the Transitional Care Unit quality meetings. d) Overall results are reported to the hospital-wide Quality/Safety Committee on a monthly basis, and will be forwarded to the Board of Trustees every other month until the audits are completed.	Began 06/09/14 –ongoing Began 06/09/14 -ongoing Began 06/09/14 -ongoing Began 06/09/14 -ongoing; add to Board agenda by 01/09/15
F 371 SS=F	C/O #33965 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or	F 371 F371	1) The TCU Administrator determined that no residents were adversely affected by this deficiency.	During the survey

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F 371	Continued From page 5 considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and interview, the facility failed to maintain a sanitary kitchen by not properly cleaning kitchen equipment and storing, dating, and labeling prepared food. The findings included: Observation with the Dietary Manager on December 15, 2014, at 8:20 a.m., in the kitchen revealed yellow dried food particles on a metal serving pan, and stored on the baking rack. Observation with the Dietary Manager on December 15, 2014, at 8:30 a.m., of the reach-in freezer revealed two opened, uncovered bags of french fries and one box of biscuits. Observation with the Dietary Manager on December 15, 2014, at 8:35 a.m., of the prep cooler (prepared food items storage) revealed a container of undated, unlabeled sliced yellow cheese. Review of facility policy, Production, Purchasing, Storage: Food and Supply Storage Procedures, revised September 2014, revealed "...all food, non-food items and supplies used in food	F 371	2) Each resident has the potential to be affected by this deficiency; therefore the TCU Administrator oversaw implementation of the following actions: 3) a) Proper pot washing procedures were reviewed with involved sanitation staff during the survey by the Director of Food and Nutrition Services. The policy entitled "Cleaning of Food and Nonfood Surfaces" was reviewed and determined to be adequate. All sanitation staff will be re-educated on proper procedures by 01/09/2015 by the Director of Food and Nutrition Services via review of this policy. b) Proper storage, dating, and labeling procedures were reviewed with involved production staff during the survey by the Chef. The policy entitled "Food and Supply Storage Procedures" was reviewed and determined to be adequate. All production staff will be re-educated on proper procedures by 01/09/2015 by the Director of Food and Nutrition Services via review of this policy. c) The policies "Cleaning of Food and Nonfood Surfaces" and "Food and Supply Storage Procedures" are covered during new associate training.	Dates as noted below 01/09/15 01/09/15 Current & Ongoing

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F 371	Continued From page 6 preparation shall be stored in such a manner as to prevent contamination..." Further review revealed "...cover, label and date unused portions and open packages..." Interview with the Dietary Manager on December 15, 2014, at 8:45 a.m., in the kitchen confirmed the facility had failed to maintain the cleanliness of the serving pan, and failed to label, date, and cover prepared foods.	F 371	d) Daily line-ups are held in the Dietary Department during which patient safety topics are routinely discussed in an effort to provide safe care and hygienic sanitary conditions. e) The Chief Dietician participates in the hospital-wide Daily Safety Huddles, so that any issues which impact patient safety are able to be quickly escalated to the hospital leadership team for resolution.	Current & Ongoing Began 08/25/14 -ongoing
F 372 SS=F	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and interview, the facility failed to maintain a clean area at the dumpsters for one of two dumpsters reviewed. The findings included: Observation with the Dietary Manager and the Environmental Manager on December 15, 2014, at 2:45 p.m., of the dumpster area revealed one dumpster with a steady stream of milky blue liquid draining from under the dumpster, and pooled against an adjoining building. Continued observation revealed a congealed white substance on the pavement. Review of facility policy, Sanitation and Infection Control: Solid Waste Disposal, revised January 2014, revealed "...food waste and rubbish...will be	F 372	4) a) A specific line item was added to the existing Food Safety & Sanitation Audit form to inspect a random sample of 30 pots/pans per week for cleanliness. Any noted deficiencies will be used as a learning tool for staff and leadership. Audits are conducted by the Director of Food and Nutrition Services or the Manager on Duty. b) A specific line item was added to the existing Food Safety & Sanitation Audit form to inspect all food in one random cooler / refrigerator per week for proper storage, dating, and labeling. Any noted deficiencies will be used as a learning tool for staff and leadership. Audits are conducted by the Director of Food and Nutrition Services or the Manager on Duty.	Audits started week of 12/29/14 Audits started week of 12/29/14

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F 372	Continued From page 7 disposed of in an approved manner to prevent contamination..." Interview with the Dietary Manager and the Environmental Manager on December 15, 2014, at 2:55 p.m., at the dumpster area confirmed the facility had failed to dispose of garbage and refuse properly.	F 372	c) Results of audits and actions taken in response to results will be reported to the hospital-wide Quality/Safety Committee on a monthly basis and the Infection Control Committee every other month. Random audits will continue until 6 consecutive months of full compliance is achieved. d) Infection Control Practitioners will investigate any report of unusual patient symptoms which could indicate potential food-borne illness, and routinely track and trend patient laboratory results for the same. Results of investigations are reported to the Infection Control Committee every other month.	To start with January 2015 QSC meeting. Add to the ICC agenda by 01/09/15 Current & Ongoing
		F372	1) The TCU Administrator determined that no residents were adversely affected by this deficiency. 2) Each resident has the potential to be affected by this deficiency; therefore the TCU Administrator oversaw implementation of the following actions:	During the survey Dates as noted below

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N 000	Initial Comments A licensure survey and complaint investigation #33965, were completed on December 15, 2014, through December 17, 2014, at Tennova Transitional Care Unit. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000	3) a) The dumpster area was cleaned by Engineering staff on 12/17/14. b) Daily cleaning procedures for the dumpster area were reviewed with involved staff during the survey by the Plant Manager. The policy entitled "Large Compactor" was reviewed and determined to be adequate. All applicable Engineering staff will be re-educated on proper procedures by 01/09/2015 by the Plant Manager via review of this policy. c) The policy "Large Compactor" is covered during new associate training. d) A member of the Engineering Department participates in the hospital-wide Daily Safety Huddles so that any issues which impact patient safety are able to be quickly escalated to the hospital leadership team for resolution.	12/17/14 01/09/15 Current & ongoing Began 08/25/14 -ongoing

Division of Health Care Facilities

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N 000	Initial Comments A licensure survey and complaint investigation #33965, were completed on December 15, 2014, through December 17, 2014, at Tennova Transitional Care Unit. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000	3) a) The dumpster area was cleaned by Engineering staff on 12/17/14. b) Daily cleaning procedures for the dumpster area were reviewed with involved staff during the survey by the Plant Manager. The policy entitled "Large Compactor" was reviewed and determined to be adequate. All applicable Engineering staff will be re-educated on proper procedures by 01/09/2015 by the Plant Manager via review of this policy. c) The policy "Large Compactor" is covered during new associate training. d) A member of the Engineering Department participates in the hospital-wide Daily Safety Huddles so that any issues which impact patient safety are able to be quickly escalated to the hospital leadership team for resolution.	12/17/14 01/09/15 Current & ongoing Began 08/25/14 -ongoing

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	445360	A. BUILDING 01 - MAIN BUILDING 01 B. WING	12/15/2014

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K9999	FINAL OBSERVATIONS During the Life Safety portion of the survey conducted on December 15, 2014, no deficiencies were cited under under 42 CFR PART 483, Requirements for Long Term Care.	K9999	4) a) Engineering Boiler Room staff will document dumpster cleaning on a daily log. The supervisor will audit compliance with daily performance of dumpster cleaning and documentation of dumpster cleaning on the daily log during monthly rounds. b) Results of audits and actions taken in response to results will be reported to the Environment of Care Committee on a monthly basis and the Quality/Safety Committee on a monthly basis. Random audits will continue until 6 consecutive months of full compliance is achieved.	Daily log initiated on 01/02/15 To begin reporting during January 2015 meetings

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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